Purpose

Specify requirements for additions or changes to an agency's clinic sites for delivering WIC services.

Opening New Clinics

The State WIC Office is to be contacted to review and approve/reject any plan to open or close clinic or sub-clinic sites.

Clinic Definition

A clinic site is considered to be a unique geographical location for serving a segment of the service area. The location may provide any or all of the following functions on a routine basis:

- Application for program benefits
- Certification
- Nutrition education
- Issuance of checks

Sub-Clinic Definition

A sub-clinic site is considered to be a unique geographical location for issuing checks and/or providing nutrition education. Clients who attend these sites return to another site for certification visits.

Request Timelines

A completed request to open/close/change a clinic or sub-clinic site must be received by the State WIC Office 60 days prior to the anticipated action. Copies of the forms are included in this procedure.

Failure to submit a request to the State office at least 60 days prior to the anticipated action date may result in delayed actions for the local agency.

The State WIC Office will notify the local agency of its decision, in writing, within 20 days of receipt of the request.

Issues Impacting Approval

The State WIC Office's decision will be based on:

- The impact of the sites' opening/closing on the State's WIC Affirmative Action Plan

Issues Impacting Approval (cont.)

- The availability of funds
- The location of near-by alternative sites
- And the current socioeconomic, medical, and nutritional needs of the population in that area.

Clinic Numbers

For new clinics the State WIC Clinic Services Coordinator will assign clinic codes to all clinic sites. These codes will be utilized for automated data processing functions, and Centers For Disease Control PNSS and PEDS data collection.

Allowable Costs

Allowable costs associated with opening/closing clinic sites are outlined in Volume V, Section E of the Procedure Manual.

REQUEST TO OPEN A CLINIC
NEBRASKA WIC PROGRAM

A. Basic Information

Local Agency _____ Date _____

Agency Contact _____ Phone _____

Clinic Name _____ Anticipated Date of Action_____
Town/Address of Site_____
Name of Building _____ Clinic Phone Number_____
Closest Clinic Site of your or any other WIC agency:

Name _____ Distance
Name _____ Distance _____

B. Services Provided (All Clinics or Sub-Clinics)

WIC Services planned at this site (Check all that apply):
☐ Certification ☐ Education ☐ Check Issuance

Proposed Hours/Day at this site _____
This site will operate (check all that apply):

☐ Through lunch hour
☐ early morning hours, specify
☐ evening hours, specify
☐ weekend hours, specify

Proposed number of days/month at this clinic site _____
Anticipated caseload _____
Check issuance at this site is or will be: ☐ Monthly ☐ Bimonthly

Is this clinic located in a hospital or operated in conjunction with a hospital? ☐ Yes ☐ No

Staff available at this clinic (please check all that apply and indicate number):
☐ Clerk(s) _____ ☐ Nurse(s) _____
☐ Nutritionist(s) _____ ☐ Translators _____
☐ Other(s) _____ Specify language _____

C. Fiscal Considerations:

Equipment purchases required to open this site:

Item	Number Needed	Cost

Blood Work Equipment: (check)
☐ Hemocue

Measuring Board(s): (check)
☐ Infant ☐ Adult ☐ Convertible

Scale(s): (check)
☐ Adult ☐ Infant

Local agency's current budget is adequate to cover costs of opening new clinic:
☐ YES ☐ NO ☐ Not Applicable

D. Integration of Services

Other health services are: (check one)

- ☐ not available at the site.
- ☐ available at the site during the same hours on the same day as WIC clinic.
- ☐ available but not the same day and/or time as planned WIC services.
- ☐ integrated (ie. shared staff, facility).

Other HHSS Programs are: (check one)

- ☐ not available at the site
- ☐ available at the site during the same hours on the same day as the WIC clinic.
- ☐ available but not at the same day and/or time as WIC services
- ☐ integrated.

Other services available at this location, at the same time as WIC clinic (please list):

Other programs/services who use this site on a routine basis (please list):

E. Special Populations

Who are the clients to be or who are served at this site? (Please list)

What type of facility is the site (day care center, hospital, business, college campus)?

Will this site serve clients who do not speak English? ☐ YES ☐ NO
If yes, indicate what languages?

Why is this site a good choice for the population you wish to serve? Be specific.

F. Facility Assessment

Is the facility handicap assessable? ☐ YES ☐ NO

If no, describe how you plan to serve clients with physical disabilities at this site:

Is there adequate parking? Please describe.

The clinic is:

☐ On a bus line

☐ Less than five blocks from the closest bus stop.

Other public transportation is available.

Specify _____

☐

☐ Bus Service not available

☐ More than five, but less than ten blocks from the closest bus stop.

More than ten blocks from the closest bus stop.

Is this site smoke free? ☐ Yes ☐ No

If clinic is located in, or in conjunction with a hospital, describe what plans are in place to provide potential participants with information about WIC and certify clients in the hospital:

Please attach a map of the facility and indicate where the WIC clinic will be held. Show where clients will enter and leave, waiting, check issuance, education, and certification areas on the map. (A hand drawn map is acceptable.)

G. Justification

Describe why you wish to open a new clinic at this location?

H. State Use Only

Date Received _____ Date Action to Happen _____ 60 Days or More ☐ YES ☐ NO

Assessment Total _____ points. ☐ Approved ☐ Not Approved

☐ Approved with the following conditions:

Comments:

Clinic Name _____

Clinic Number _____

Agency Name _____

Agency Number _____

County Name _____

County Number _____

Altitude _____

Effective Date _____

Date Entered into System _____

Date CDC Notified _____

Date L.A. Notified _____

NOTICE OF CHANGE IN WIC
CLINIC LOCATION AN/OR SERVICES

A. Basic Information

Local Agency _____ Date _____

Agency Contact _____ Phone _____

Clinic Name_____ Anticipated Date of Action _____

B. New Location

Address _____Phone _____

Why:_____
_____
_____

Is this location in a hospital or operated in conjunction with a hospital? ☐ Yes, complete section _____ ☐ No

Is this location smoke free? ☐ Yes ☐ No

Is this location handicap accessible? ☐ Yes ☐ No, complete section _____

C. Change In Services

Indicate an "A" beside each area you are planning to add at this site.
Indicate a "D" you are planning to discontinue at this site.

☐ Certification ☐ Education ☐ Check Issuance ☐ Number of Days at Clinic ☐ Weekend Hours

☐ Evening Hours ☐ Other Health Services
Specify _____
_____

☐ Other HHSS Programs
Specify _____
_____

REQUEST TO CLOSE A WIC CLINIC

A. Basic Information

Local Agency Name_____ Date _____

Clinic Name_____ Proposed Closing Date _____

Contact Name _____ Contact Phone _____

Current Clinic Caseload _____

B. Why you wish to close this clinic (check all that apply)

☐ Cost ☐ Loss of Space ☐ Small Caseload ☐ Travel Issues

Explain:

C. How will WIC Services be provided to current and potential clients who live in this area in the future?

State Staff Use Only:

☐ Date Received ☐

☐ Approved Not Approved

Approved with following conditions:

Date entered into system: _____
Date CDC notified: _____
Date Local Agency notified: _____